# Housing First Roundtable Report

**NC Interagency Council for Coordinating Homeless Programs**

(ICCHP)

August 30, 2005

**N.C. Interagency Council for**
**Coordinating Homeless Programs**

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## Executive Summary

On August 30, 2005 the N.C. Interagency Council for Coordinating Homeless Programs (ICCHP or Council) hosted a Housing First Roundtable, bringing together representatives from State agencies and eight local communities. The Roundtable agenda included a presentation on the Housing First/Housing Plus program model by Sam Tsemberis of Pathways to Housing. Pathways to Housing has been cited by the U.S. Interagency Council on Homelessness as a model Housing First/Housing Plus program. The Roundtable also included extensive discussion about how well North Carolina communities are able to implement the Housing First/Housing Plus program model with its homeless population and what steps need to be taken to improve our capacity to develop permanent supported housing with appropriate support services.

## Recommendations

**New Resources:**

The Roundtable participants identified two crucial areas for new resource development – ***rental assistance/operating subsidy and services for non-Medicaid eligible individuals***. While the group spent some time identifying existing resources that may be currently underutilized, it was clear that the gap between those relatively small sources and the funding needed is significant and will not be met without investment of new resources or shifts in existing resources. The participants were aware that while research shows that investment in services and housing assistance will pay off in the long run, there is undoubtedly an up-front cost to set needed programs in motion. ***Committed, recurring funds for rental assistance/operating subsidy and for services are necessary for implementation of permanent supported housing***. Without such resources, implementation of the 10 Year Plans to End Homelessness from communities across the state will have limited impact. Yet, due to the growing awareness of the effectiveness of the permanent supported housing and the Housing First model, when the resources are made available they will be used effectively – for the State, for communities, and for individuals.

**Education:**

Roundtable participants repeatedly remarked that successful implementation of the Housing First model is made difficult by a general lack of understanding about the model, how to implement it, its effectiveness, and its long term cost benefits. The group identified various audiences to target for awareness, including legislators, Local Management Entity (LME) boards, direct service staff, including staff for ACTT, CST, CS and PATH providers, and the general public.

***Legislators*** - Most in the group felt that legislators should be the first group targeted for education about the Housing First model. The primary emphasis for this audience would be long term cost savings that follow short term start-up costs, the overall success of the model, and ways that legislative action – including identifying targeted funding – is needed to support statewide implementation.

***Local Management Entity Boards*** – This audience would primarily benefit from education about the long term cost savings that follow short term start-up costs, the overall success of the model, specifics of how person centered services – including employment services – should be provided, building relationships with landlords, and funding mechanisms.

***Direct Service Staff*** – This audience would primarily benefit from education about the specifics of how person centered services – including employment services – should be provided for homeless and recently homeless individuals, how to engage the homeless population, building relationships with landlords, and funding mechanisms.

***General Public*** – This audience would primarily benefit from information about cost savings, the overall effectiveness of the model, and recognition of community responsibility for this population and the solutions.

**Program:**

***Shelter Plus Care (S+C)*** – This federally funded program which has possibilities for gradual expansion was acknowledged as a crucial resource for rental assistance for homeless people moving into permanent housing. Yet, the dollar for dollar services match is difficult for persons who have recovered from their mental illness and no longer need intensive services. ***Therefore, it is recommended that either the S+C program be modified to provide flexibility for individuals who have fewer service needs or that a different source of long-term rental assistance free up existing S+C vouchers for new program participants who do have intensive service needs***.

***PATH and Mental Health services*** – The Roundtable participants from several communities named the need to have a better relationship between existing PATH workers and long term mental health services. Specifically, in several communities homeless individuals face a dangerous gap in services between the time that PATH workers assist them into housing and the time that other mental health workers pick up the new client. ***Many communities need a smoother transition from PATH to mental health – either through improved communication between PATH and mental health, a mandated timeline for transition from the PATH caseload to the mental health active caseload, or by using PATH funds in conjunction with other funding streams to give treatment teams the capacity to do homeless outreach and follow-up with an individual placed in housing while maintaining a continuity of staff***.

***Services*** – Communities must develop comprehensive service models that maximize desired housing stability and cost effectiveness outcomes. ***The service models should incorporate several features, including but not limited to components identified during the Roundtable.***

- Services should be more comprehensive than traditional treatment and therapy.
- Employment, training and education services must be included in the comprehensive services menu.
- Landlords are an ally of the services team. Landlords should have assurances that tenants will receive needed services and also be creatively supported when problems arise.
- Less intensive, maintenance services should be available for individuals who recover from their mental illness.
- Trauma services should be available for all populations, including those persons with mental illness, substance abuse, or no identified diagnosis.
- Substance abuse services must be made available immediately when individuals request treatment.
- Income supports are needed by many, including individuals who join the workforce and may still need transitional income supports.

## The Roundtable – An Overview

The Housing First Roundtable was sponsored by the N.C. Interagency Council for Coordinating Homeless Programs on August 30, 2005. The Roundtable was designed to bring select representatives from eight communities that were in the process of developing or implementing Housing First style programs in North Carolina. After hearing a presentation on the model from Sam Tsemberis, Executive Director of Pathways to Housing, these community representatives engaged in a full day discussion with state agency representatives. The discussion focused on how urban and rural communities can implement the model effectively using federal, state and local resources. The group assessed current capacity and identified recommendations for improved implementation.

## Background

Housing First/Housing Plus, or Rapid Re-Housing with support services, has been documented as highly effective in stabilizing chronically homeless persons with mental illness in a cost effective manner, resulting in the end of homelessness for those individuals. As a point of clarification – this research has not shown that housing alone makes the difference, but it clearly demonstrates that housing with support services is effective and efficient. Likewise, we are learning that services without permanent housing have a limited impact on many homeless persons' lives. The combination, permanent housing and appropriate services, is ending homelessness.

For several years, the Department of Housing and Urban Development (HUD) has been acting on a Congressional mandate to prioritize permanent housing projects for funding with the competitive McKinney Vento grants. Encouraging Housing First/Housing Plus projects refines that existing policy directive. While HUD is not limiting its homeless permanent housing funding to projects serving chronically homeless, mentally ill individuals, that subpopulation is receiving a significant priority.

Partially in response to the HUD priority, and partially in response to their own analysis of community needs, local homeless service providers are submitting project applications to fund permanent supported housing – both through the Supportive Housing Program (site based projects) and the Shelter Plus Care program (rental assistance projects). A significant percentage of these new project applications are targeting the chronic homeless population, and within that population most projects are targeting persons with mental illness.

Other HUD funded projects seek to provide permanent housing to families with disabled members and/or individuals with substance abuse disabilities not accompanied by mental illness. Likewise, some communities are seeking other sources of funding to create permanent supported housing for disabled and non-disabled homeless persons.

As a result, North Carolina communities are increasing the number of permanent supported housing projects they are developing for homeless persons and families, particularly for those with mental illness and other disabilities. Yet, the link between

housing and services is inconsistent, and in some communities it is very tenuous. Since the research is very clear that permanent housing is a successful antidote to homelessness only when accompanied by appropriate services, it is crucial that communities in North Carolina develop successful working relationships between the providers of permanent housing, both existing and new, and our existing and new service providers.

## What is Housing First/Housing Plus, Rapid Re-Housing and Permanent Supported Housing?

Over the past few years, the term Housing First has come to mean many things to different people, especially among homeless service providers. Several program styles and policy initiatives are included in the N.C. Interagency Council for Coordinating Homeless Program's (ICCHP) commitment to Housing First, as long as the programs include the core components of Housing First. Although Housing First is linked foremost to efforts to end chronic homelessness, the ICCHP recognizes that its principles are applicable to almost all subsets of the homeless population. ***At its core, Housing First is a model that links permanent housing and appropriate, client centered support services***. It is the ICCHP's desire that Housing First be implemented in all communities where it is needed, with any homeless population for which is it effective.

- *In its best known application, Housing First refers to a strategy that includes moving homeless people with mental illness and other disabilities off the streets and placing them directly into permanent housing, linked with comprehensive services*. Individuals are engaged by Assertive Community Treatment Teams (ACTT) programs that provide a continuity of services, beginning while the individual is on the street or in shelter and continuing after placement into permanent housing. *The Housing First strategy makes minimal use of shelters and hotels, using them only as a placement between the time that an individual names a desire to move off of the streets and the time that it takes for the program to prepare an apartment*. Individualized, client centered services are provided as long as the services are needed by the client. Yet, participation in a treatment plan is not a requirement for remaining in housing as housing itself is deemed a critical component of a successful treatment plan. Tenants must comply with landlord-tenant law, and may be evicted for the same reasons as other tenants, but they are not evicted for compliance issues beyond what is expected of any other tenant in any other apartment. In this application, a crucial programmatic feature is the awareness that the greatest stability is reached when all services that an individual requires and benefits from are provided in the context of permanent housing. Individuals who do not need hospitalization are served best in a permanent setting, and necessary services must be provided in that setting.

- Most homeless service providers are aware that a large percentage of people who experience homelessness do not meet the definition of an individual with disabilities who is experiencing long-term homelessness. *Some of the most creative and effective adaptations of the original Housing First model involve permanent supported housing for families and individuals without disabilities*.

*The basic principles of the model remain in place – that homeless families and individuals are moved into permanent housing as quickly as possible rather than placed in shelters and transitional housing. Furthermore, the service providers who engage the family or individual while they are homeless continue to work with that household after placement in permanent housing*. Once again, shelters and hotels are used only as a placement between the time a family or individual names the desire to move off of the streets and the time that it takes the program to prepare an apartment. A significant difference, however, may be found in the type and length of services that are provided. With a household that does not have any members with chronic disabilities, there is great likelihood that there will not be a need for permanent services, with the possible exception of ongoing rental assistance. Instead, the program commits to providing whatever services are needed for as long as the services are needed, whether that is for two months, two years, or 10 years. Yet, once the services are no longer needed, the family or individual is allowed to remain living in the same permanent housing. Therefore, stabilization is not threatened by a physical move at the same time that services are being discontinued.

- *Some providers implement this strategy by redesigning transitional housing programs into "transition in place" programs*. A transition in place model allows the household to remain in the home where they have been receiving transitional housing services, even if that home is in a group setting with other households that have been receiving services. *Once the household no longer needs services, instead of moving the household the service provider moves and begins providing services in another permanent housing setting*. The flexibility of this model allows maximum use of various housing types to meet individual needs. For example, this model can be implemented with families in a triplex, or individuals engaged in substance-abuse recovery who are benefiting from peer-support in a shared living arrangement. In either case, once the household no longer needs interventions by professional services, they are able to remain in the same physical setting with the same social supports that have been crucial to the ability to live independently.

- *In most cases, when implementing a Housing First program for individuals with substance abuse issues, permanent housing is seen as the appropriate placement post-treatment*. Individuals who complete substance abuse treatment programs are engaged and linked with permanent housing options, rather than being sent to shelters or the streets. Support services, including peer supports, continue. In some cases the permanent housing is shared living or congregate living – providing a more complete peer-support environment. Yet, when the individual or family moves into this housing it is accepted that they can stay permanently, or as long as they wish to stay. There is no pre-determined, program based exit date.

  *There are some programs, however, that provide permanent housing for individuals with substance abuse disorders who are not engaged in treatment*. The best known of these models is the Safe Haven – a low demand, small group housing with 24 hour services that are aimed at harm-reduction. Individuals with

substance abuse disorders or dual diagnosed with mental health and substance abuse disorders are allowed to stay in the housing until they decide they are ready to seek treatment or move to other housing settings.

## Implementing Housing First

In part, implementing Housing First with a diversity of subpopulations within the homeless community means that some funding sources and housing types can be accessed by some of the clients, but not necessarily all clients or all subpopulations. Therefore, the ICCHP must explore how well our housing and service systems can support this model in all of its variations.

***Homeless Persons with Mental Illness and Other Disabilities covered by SSI, SSDI and Medicaid***

In most communities a community services infrastructure is usually either already in place or is being developed for an individual with mental illness or with dual diagnosis who is already on SSI, SSDI and/or Medicaid. The depth and breadth of that infrastructure, and the service provider's familiarity with homeless people, is still a function of where a community is in developing a private provider network as part of the Mental Health Reform process.

The first step of Housing First from the client perspective is engagement. The proposed service definitions for Community Support (CS) for Adults with Mental Illness and/or Substance Abuse Disorders, Community Support Team (CST) for Adults with Mental Illness and/or Substance Abuse Disorders, and Assertive Community Treatment Teams (ACTT) for Adults with Mental Illness all allow for engagement, even if the engagement begins on the street, although state funds are not available until *after* a mental health case is opened by the LME. Therefore, these activities can support efforts to engage someone into housing once they've agreed to mental health services. As one way to supplement outreach activities eleven communities have federal PATH grants that providing funding for staff specifically targeting outreach and engagement services to mentally ill persons on the streets and in shelters that occurs *before* the individual has agreed to accept mental health services.

The three proposed service definitions (CS, CST, and ACTT) also allow for ongoing services to the individual once that person has moved into permanent housing. ***The service definitions are flexible enough to support the community support, non-treatment interventions that are crucial to residential stability***. To receive reimbursements for providing these services, the service provider must be under contract with the Local Management Entity (LME) for that geographic region and the LME acts as the coordinator for the services provided to clients.

## Issues Raised During the Roundtable

### *Separating Housing and Services*

*One of the most distinguishing features of the Housing First model, especially in comparison to traditional homeless services, is the separation between housing and services*. Specifically, compliance with services is not a requirement for housing. Tenants may be evicted for violations of their lease – as with normal landlord-tenant arrangements, but not for violations of their services agreements. Indeed, services are frequently in place to help ensure that the tenant is able to comply with their lease, and some services may be aimed at minimizing risk factors for landlords. Ultimately, however, tenants would not be evicted merely because they did not comply with a treatment plan. In most cases separate agencies are providing the housing and services, and if not separate agencies, then distinct divisions within a larger agency. The model discourages having the same staff act as both service provider/advocate and landlord/enforcer.

### *Responsibility for coordination of services*

Very few homeless service agencies currently have the staff capacity to meet the requirements necessary for contracts with LMEs. Participants in the Roundtable agreed that homeless service agencies attempting to implement a Housing First program for persons with mental illness ***must*** have a strong partnership with their local LME or Mental Health Authority. While the homeless service agency may be providing or coordinating the permanent housing portion of the Housing First model, *coordination of services should be an activity of the LME, not of the homeless service agency*. Independent, nonprofit homeless service agencies do not have the authority needed to coordinate all of the needed services and to authorize funding for those services. The identification and coordination of comprehensive services needed by individuals with mental illness or dual diagnosis should be the responsibility of the LME.

### *Variations in LME readiness to ensure services are available*

At this time, LMEs have differences in their preparedness to partner with Housing First programs primarily in two ways. First, there is a difference in the *completeness of the provider network* - the qualified, contracting agencies that will provide services as outlined by the proposed service definitions. This discrepancy means that some communities do not have enough service providers to meet the need identified by the homeless service agencies, a reality faced by many of the more rural areas and some of our urban areas. The second significant difference is in *buy-in by the LME itself*. Several communities named that their LME, and specifically the LME boards, would benefit from training about the Housing First model, its effectiveness and cost savings to the community.

### *Variations in the readiness of the provider network*

Even for those communities that have an extensive provider network, not all of the network is experienced in working with homeless people, or familiar with the Housing First model. Many CS, CST and ACTT project members would benefit from training about homelessness and homeless people.

***Range of services provided***
The Roundtable participants named that *all services must be person centered, and that some services aren't specifically treatment*. Community support activities are equally necessary in housing stability. The group also acknowledged the crucial role of employment supports as a cornerstone services for successful Housing First programs.

***Acknowledging Recovery***
*Recovery can and will be achieved by at least some residents in permanent supported housing*. In those cases, housing supports may continue to be needed, but the quantity and quality of professional services interventions needed may reduce drastically. This reality may be particularly difficult if a resident continues to use Shelter Plus Care as the source of rental assistance since that program requires a dollar for dollar services match. For that reason, rental assistance programs that closely model the Section 8 program are particularly well suited for Housing First.

***Improving connections between PATH and MH programs***
Some of the 11 communities that have active PATH programs find a disconnect for the client who is handed from a PATH worker to a Mental Health worker or Mental Health services team. Communities may need to work towards improving the consistency of care, engagement by the mental health system more quickly, and possibly the continuity of staff providing the care as individuals move from the streets and into housing. It is clear that many individuals may have made decisions to move into housing, at least originally, based on their relationship with their outreach worker. Identifying ways to use that same relationship to assist in maintaining someone in housing is challenging for some communities.

***Rental Assistance***
A flexible source of rental assistance and/or operating support is crucial for implementing Housing First. Individuals with SSI level incomes will not be able to afford market rate housing in any community in our state. Even projects that develop new subsidized housing for this population will need operating or rental subsidies on a permanent basis. Current rental assistance sources, including Section 8, Shelter Plus Care, and the Housing Finance Agency's newly implemented pilot rental assistance project for the targeted units in Low-Income Housing Tax Credit developments, are not adequate to meet rental assistance needs necessary to make Housing First a viable option in North Carolina communities. Additional rent subsidies must be identified.

***<u>Homeless Persons who do not qualify for Medicaid</u>***
Not all homeless people who need short-term or long-term services are eligible for Medicaid. Service providers are usually very challenged to find funding streams to cover the cost of needed services for this population. To successfully move all homeless people off of the streets communities must be able to tap into a services funding stream that will provide funding for non-Medicaid eligible clients as well as clients who are awaiting Medicaid eligibility determination.

***Homeless Persons with Substance Abuse Only***

The Roundtable participants also discussed service needs for persons with substance abuse only. It was noted that some of the services needed by this population can be provided through the Community Supports proposed service definition associated with Mental Health Reform.

- The group recognized that even if an individual has gone through treatment programs, he or she will likely have some permanent and transitional service needs. Foremost, connection to long-term peer support, consistency with therapeutic support, is critical for individuals coming out of treatment.
- Individuals frequently need extensive employment services.
- Even those who find work quickly may need temporary income supports, including intermediate term rent subsidies. This support is needed while individuals re-establish their lives and make financial amends for previous debts. For example, many individuals will owe substantial back child support accrued while homeless and in treatment. In some cases income support can be assistance with tangible items needed to set up a household.

## Conclusion and Follow Up

In addition to developing several recommendations listed at the beginning of this report, Roundtable participants also expressed a desire to meet again within 12 – 24 months. This second Roundtable will allow communities to share best practices and lessons learned from their initial implementation of Housing First projects.

## Participants

**Asheville/Buncombe County:**
Amanda Thomas, Hospitality House of Asheville

**Charlotte/Mecklenburg**
Jermayne Cook – St. Peter's Home
Ricky Hall – Mecklenburg DSS
Karen Montaperto – Charlotte Emergency Housing
Peter Safir – Mecklenburg County
Paul Walker – Access Program
Chris Wolf – A Way Home

**Durham/Durham**
Dr. Al Mooney – The Durham Center
Doug Welleymeyer – Housing for New Hope
Dian Wilson – PATH Coordinator
Beth Melcher – The Durham Center

**Henderson/Vance**
Kim McCowan – Alliance Rehabilitative Care
Glenn Fields – Five Co. Mental Health
Felicia Garrity – VFW Opportunity Corp.
Gwen Wright – City of Henderson

**Raleigh/Wake**
Carolynn Crowder – Cornerstone
Kay Ferguson – Wake Co. Human Services
Carlyle Johnson – Wake Co. Human Services
Annemarie Maoirano – Wake. Co. Human Services
Peter Morris – Wake Co. Human Services
Mary Jean Seyda– CASA
Betty Rowland – Wake Co. Human Services

**Rocky Mount/Nash/Edgecombe**
Chris Battle – United Community Ministries
Bobby Jones – Wilson-Greene MH
Glenn Silver – City of Rocky Mount
Jerry Smith – United Community Ministries

**Wilmington/New Hanover**
Denver Brown – Southeastern Center
Susan Cain – Southeastern Center
Rebecca Dixon – Volunteers of America
Lillie Gray – City of Wilmington
Anita Oldham – Southeastern Center

**Winston-Salem/Forsyth**
Laurie Coker - CFAC
Kerry McLeod – CenterPoint
Carl Noyes – Preferred Alternatives
Tim West – City of Winston Salem

**Department of Health & Human Services - Office of the Secretary**
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Julia Bick
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**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**
Bert Bennett
Mike Moseley
Leza Wainwright
Debbie Webster

**Division of Medical Assistance**
Linda Attarian

**Division of Community Assistance**
Aaron Cain
Iris Payne

**Housing Finance Agency**
Margrit Bergholz
Mike Mittenzwei
Nancy Pearce
Mary Reca Todd

**Department of Correction**
Nicole Sullivan

**Governor's Policy Office**
Walker Wilson

**U.S. Department of Housing & Urban Development**
Libby Stanley

**Regional & Statewide Associations**
Stan Holt, Triangle United Way
Don Stedman, Commission for Mental Health, Developmental Disabilities, Substance Abuse